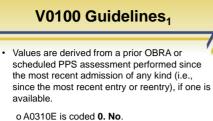
Care Area Assessments (CAAs) & Care Planning	
Section V	
Item V0100 Items From the Most Recent Prior OBRA or PPS Assessment	



· Skip V0100A, B, C, D, E and F on the first assessment (OBRA or PPS) following the most recent admission of any kind.

o A0310E is coded 1. Yes.



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V0100 Guidelines,

- · Complete V0100 only if:
 - o A prior assessment has been completed since the most recent admission to the facility.
 - o The prior assessment was a Federal OBRA assessment OR a PPS assessment.
 - o Prior discharge or entry records are not considered or included in this list.







V0100A & V0100B Coding

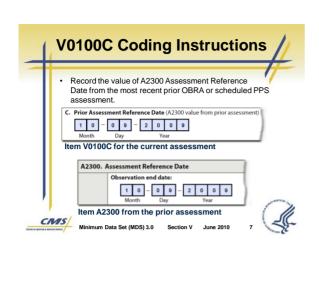
- V0100A and V0100B cannot both be 99.
- Complete this item for the most recent prior OBRA or PPS assessment only.

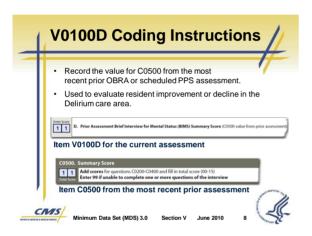
	Rems From the Most Recent Prior OBRA or Scheduled PPS Assessment e only if A0310E = 0 and if the following is true for the prior assessment: A0310A = 01-06 or A0310B = 01-06
Enter Code	A. Prior is insurement Federal CBBAR Associa for Assessment (ACS) 104 value from prior assessment) 1. Admission insurement (operating 4 of part 2. Quarterly vironic assessment 3. Quarterly vironic assessment 4. Significant ceres (continued on the continued of part 5. Significant ceres (continued on the continued on the con
Enter Code	E. Prier Assessment PS hasses for Assessment (A01)80 value from prior assessment0 1. 8-99 vin-bulles seasoment 1. 8-94 yis-bulles seasoment 1. 8-94 yis-bulled seasoment 1. 8-84 yis-bulled seasoment 1. 94

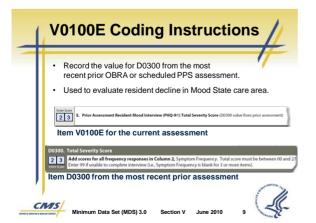


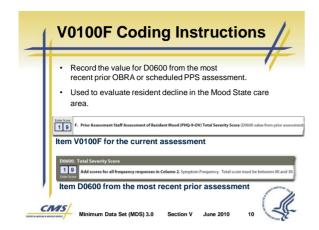
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Item V0200

CAAs and Care Planning

· Documents: o Which care areas triggered and require further assessment o Whether or not a care area is addressed in the resident care plan

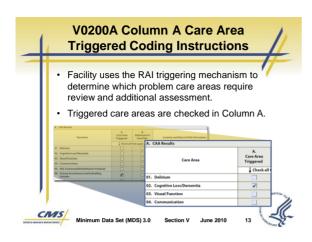
V0200 CAAs and Care Planning

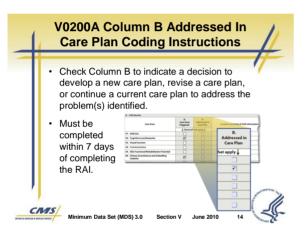
- o Location and date of CAA information
- · Reflects the IDT and resident's decisions on which triggered conditions will be addressed in the care plan.

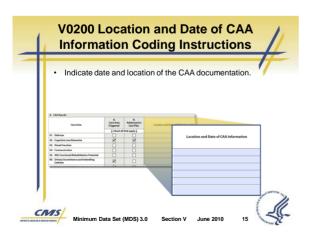


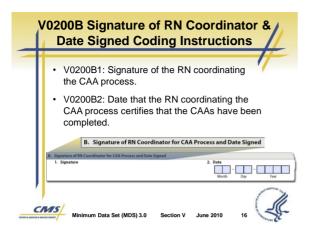
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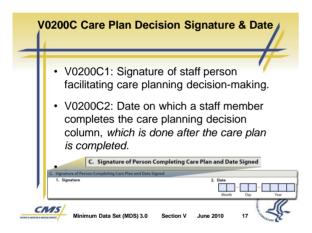




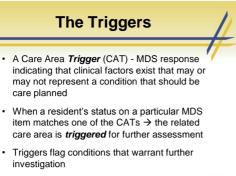










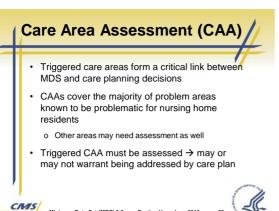


Trigger Legend in Chapter 4 lists the triggers

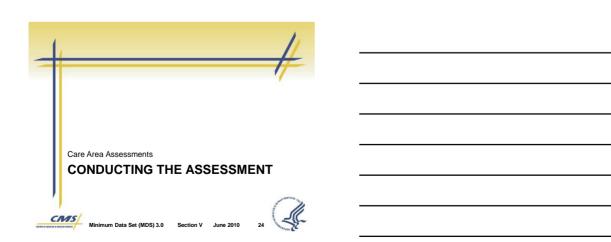
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The Triggers • A care area may be triggered by: o A single MDS response option o A combination of more than one response options o A comparison of resident's status on current assessment and prior assessment









Step 1: Identify the trigger • Usually a sign, symptom, or other indicator of possible problem, need, or strength Example Acute onset of mental status change (C1600)

Step 2: Identify the triggered Care Area Example Acute onset of mental status change (C1600) triggers Delirium care area

Step 3: Conduct thorough assessment of the entire Care Area Include factors that could cause or contribute to the symptom Include factors for which the symptom places the resident at risk Some factors will be on the MDS, many will not Minimum Data Set (MDS) 3.0 Section V June 2010 27

Conducting the Assessment Tools Requirement

- Must be current, evidence-based or expert-endorsed research and clinical practice guidelines/resources
- · The facility should be able to identify the resources they use upon request
- Requirement is consistent with F492 services must meet professional standard of quality



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Appendix C Resources

- Staff should follow their facility's chosen protocol or policy for performing the CAA.
- Resources provided in Appendix C are not mandated.
- · CMS does not endorse the use of any particular resource(s) including those in Appendix C.
- Resources selected may be used outside of RAI process also





Conducting the Assessment

Tools Option 1

- · Review of Indicators for each care area provided in Appendix C
- · Each provides a checklist of indicators that guides the assessment for the particular care area
- · Also provides location and guidelines for documentation



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Conducting the Assessment Tools Option 2 • Appendix C also offers a list of resources that may be used for this purpose • May be accessed online or through professional associations or other organizations • Not an exhaustive list – providers are free to use others that meet regulatory requirement

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Conducting the Assessment

Step 4: Draw conclusions based on the information collected

- What is causing or contributing to the problem for this resident?
- What is this resident at risk for related to the problem?
- What other health professionals should be involved?



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CAA Documentation

- . The nature of the issue or condition what is the problem for this resident?
- · Causes and contributing factors
- · Complications affecting or caused by the care area for this resident
- Risk factors that arise because of the presence of the condition
- Factors that must be considered in developing individualized care plan interventions
- Need for referrals to other health professionals

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CAA Documentation

- · Written documentation of the CAA findings and decision-making process may appear anywhere in resident's record
- · No particular location or format is required
- · Section V indicates Location and Date of CAA documentation r/t decision-making



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CAA Documentation

Popular Formats

- · Checklist with summary analysis
 - o See Jane Doe Delirium Review of Indicators





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CAA Documentation Popular Formats CAA review note summarizing and analyzing findings o See next slides CNIS/ Minimum Data Set (MDS) 3.0

Delirium Review Note Jane Doe Possible causes and contributing factors: o Pulse < 60 r/t Digoxin (MARs) Low sodium (2/20/10 lab work), takes Lasix and K+ (MAR) Blood sugar fluctuations (MARs) CHF w/ pulmonary edema prior to admission, hx MI, cardiac dysrhythmias (H&P) SOBOE with PT (PT notes 2/19, 2/20, 2/23, 2/25, 2/28) Hypothyroidism, renal insufficiency (H&P) o 30 lb. unplanned weight loss in year prior to hospitalization (H&P and wife) ADL decline within last 6 months (per wife and resident) o Remeron dose increased 2/20 (MD orders and MAR) o Nightmares last three nights (nurses notes) Seeing murals, hearing music that wasn't there (NN 2/25-2/27) Recent move from Atlanta to Phoenix (transfer documents, SS assessment)

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Lost hearing aids during move Newly admitting to SNF 2/18
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Analysis of Findings: Jane Doe · This analysis would be the same as the analysis on the last page of the Delirium Review of Indicators checklist for Jane Doe. because format does not change content requirement o Description of the problem o Causes and contributing factors o Risk factors

Delirium Review Note

CAA Documentation Popular Formats • No additional note or summary other than routine chart documentation o In section V assessor provides locations in the chart where information is located In some cases, it may be prudent to write a summary of the CAA information, especially if the assessment documentation in the record is incomplete, unclear, too scattered, or unfocused. It may also be useful to have the information summarized for quick reference by staff Minimum Data Set (MDS) 3.0 Section V June 2010 40

Regardless of tool or format, documentation should walk through the evidence of and conclusions about the root causes, contributing factors, risk factors, referrals to other health professionals

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RAI Manual Chapter 4

Individualized Care Through Evidence-Based Assessment and Care Planning

Objectives

- To review the care processes underlying assessment and care planning
- · To consider key criteria for evidence-based care
- To help facilities identify an efficient and effective approach to evidence-care planning
- To show how evidence-based care planning can help attain individualized ("person-centered") care



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Background

- · Per OBRA '87, facilities must
 - o Provide necessary care and services
 - o Attain improvement when possible
 - o Avoid decline unless unavoidable
 - Complete comprehensive, standardized assessment
 - Use results of assessment to develop, review, and revise each resident's comprehensive plan of care



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Uses and Cautions

- Most tools and products have accompanying information
 - o Extolling virtues
 - o Giving directions for use
 - o Offering cautions and warnings
- Especially vital when improper or nonindicated use has potential for major complications



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Uses and Limits of the RAI RAI is meaningful and helpful when used

- correctly for intended purposes
- · RAI use can be a problem; especially if
 - o Used without adequate understanding
 - o Used in a manner that exceeds the user's knowledge and understanding
 - Used for purposes for which not designed
- Skill of assessors can vary greatly, just like automobile driver or cyclists



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Key Issues

- · What is the clinical standard of practice?
 - o How does it differ from "common practice" or "conventional wisdom?"
- · What does it mean to give evidence-based care?
- o In contrast to allegations thereof
- · What is evidence-based care?
 - o Requires applying BOTH
 - Evidence about the resident/patient AND
 - Evidence about assessing and managing resident/patient's risks, conditions, and symptoms



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Going Beyond the RAI

- · Federal requirements for ongoing assessment responsibility
- · Quality of Care regulation (42 CFR 483.25 [F 309])
 - o Necessary care and services to attain or maintain highest practicable physical, mental, and psychosocial well-being
 - In accordance with comprehensive assessment and plan of care



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RAI and Beyond: Professional Standards

- Services provided or arranged must meet professional standards of quality
 - o F492 42 CFR483.75(b)
- Elements of assessment and care that are consistent with professional standards
 - o OBRA regulations and guidance (e.g., F314 42 CFR 483.25(c) Pressure Ulcers and F329 42 CFR 483.25(l)(1), Unnecessary Medications)
- Responsibility to assess and address all care that is needed by individual residents, regardless of whether covered by the RAI

o F272 42CFR483.20(b)

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Steps to Evidence-Based Care

- · Collect and analyze information
 - in order to perform
 - Accurate problem definition & cause identification
 - resulting in
 - Effective clinical problem solving and $\,$ decision making

leading to

- Appropriately individualized interventions

Adapted from: Levenson SA. The basis for improving and reforming long-term care, Part 2: Clinical problem solving and evidence-based care. J Am Med Dir Assoc 2009; 10: 520–529.



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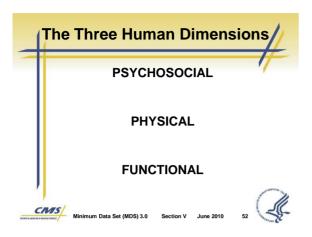
Steps to Evidence-Based Care

- Critical intermediate steps in between collecting information and choosing interventions
 - Accurate problem definition and cause identification
 - Effective clinical problem solving and decision making
- RAI and related guidance not designed or intended to cover intermediate steps fully
 - o Only offers a general framework



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Health, Illness, and Impairment

- · Health can be defined as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" - World Health Organization (WHO)
- · Health care alone is unlikely to produce "health"
 - However, it can affect well-being profoundly, for better or worse



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Sound and Unsound Care

- Sound
 - o Care of person with [Condition A + Condition B + Condition C + Condition D + Condition E]

- Unsound
 - o [Care of Condition A] + [Care of Condition B] + [Care of Condition C] + [Care of Condition D] + [Care of Condition E]

-	1	76

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Care in Context

- · Fragmented or uncoordinated ("silo") care
 - o Biologically unsound because it
 - Is not based on the "big picture"
 - · Approaches issues as distinct entities
 - Fails to identify root causes
 - Fails to address causes and consequences in proper context
 - May cause new or additional complications while trying to address issues in isolation



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Sound Care: History and Context

- What are the likely differences in cause, approach, and context if someone
 - o Gets delirium and then gets anorexia
 - o Gets anorexia and then gets delirium
 - o Has a significant condition change with change in mental function and anorexia at the same time
- · MDS 3 / RAI focus on "interview"
 - o But only for several areas
- Key element of history taking applies across the board



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Evidence-Based Care

- Evidence-based care refers to evidence about the illness, symptom, condition, or risk AND evidence about the resident
 - o Requires detailed and clear findings and problem statement
 - o Requires a "story"
 - Chronology of symptoms and events, not just random data / diagnoses
- Thus, a history is key to identifying causes and choosing appropriate interventions



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Comprehensive Assessment: Key Elements

- DeGowin: Bedside Assessment (original title)
 - o Since 1965, a classic reference on the key elements of history taking and examination
 - Content is universal, enduring, and relevant to anyone of any discipline who assesses a human being
 - Source: LeBlond RF, Brown DD, DeGowin RL. DeGowin's Diagnostic Examination. (9th ed). New York: McGraw-Hill, 2008



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History Taking: Key Objectives

- Taking a . . . history has four objectives:
 - o 1) Discovering symptoms (issues, concerns, wishes, goals, preferences)
 - o 2) Obtaining accurate quantitative descriptions
 - o 3) Securing a precise chronology of events
 - 4) Determining how the illness (impairment, psychosocial concern) has changed the resident/patient's life



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Implications

- Detailed chronological history and basic physical assessment are essential
 - Especially, in those with complex acute or chronic disease or multiple causes and consequences
 - o Otherwise, little more than guesswork
- History and exam help with thinking about situation and its causes
 - o Testing and consultation often less helpful



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Problem Definition

- Evidence-based care requires a clear and detailed statement of the issue
- Difference between a "chief complaint" and a problem statement
- An issue or problem is different from a finding
 - o e.g., a single piece of information from the MDS or a test result



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Defining the Issue

- · Other examples of a "chief complaint"
 - o Resident has a headache
 - o Resident is vomiting
 - o Resident cannot be aroused
 - o Resident is "agitated"
 - o Resident coughs when she eats
 - o Resident is not participating as usual
- All of these need much more detail to be meaningful



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Implications

- MDS data often at level of a chief complaint or isolated finding
 - o Missing important detail / lacks a chronological story
- · Common practice: treat/care plan chief complaint
 - o May result in inadequate or problematic care
- Important to avoid premature interpretation
 - o Such as failing to record seemingly irrelevant symptoms or events
 - o May be problematic to assume the conclusion and thereby fail to seek additional information
 - (e.g., behavior due to UTI, depression, or comfort needs



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Seeing, Hearing, and Believing

- · Common widespread advice
 - o "Believe whatever the resident tells you."
 - o "Accept whatever the resident tells you about pain"
- However, that can easily be misunderstood or misrepresented
 - o It does not mean
 - Don't question; don't challenge
 - Just take whatever you are told and act on it



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Reasonable Expectation?

- Describing and presenting detailed history is not diagnosing
 - A health care background is not required to provide symptom details
- Presenting inadequate information or conclusions / interpretations based on inadequate information often problematic
 - o May result in irrelevant / harmful interventions



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Essential Basis For Care Planning

- Evidence-based care enhanced when staff focus on
 - Carefully gathering, documenting, and reporting chronological history ("tell a story")
 - Obtaining as much detail as possible from the resident
 - Or, alternatively, constructing and reporting a good, detailed "story" as the surrogate historian
 - o Reporting and documenting objective details of observations and examinations



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Care Plan Together or Separately? · Evidence-based approach

- - o Define problem / issue / concern clearly
 - o Figure out what is linked to what
 - o Develop sound hypotheses
 - Based on careful problem definition and cause
 - o To extent possible, care plan related issues together



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Care Plan Separately or Together?

- Separate care plan often not required for each finding
 - o BECAUSE a single trigger can have multiple causes and contributing factors AND multiple items can have a common cause or related risk factors
- · THEREFORE, often appropriate to combine care plans or cross-reference related interventions



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Summary: IDT Responsibility

- Facility's IDT, including physicians, must identify causes and connect causes and consequences
 - o BECAUSE it is essential to resident-centered care and the MDS and CAAs not designed to do so
- Qualified, interested, and capable practitioners are needed
 - o Identify multiple causes of a single problem or multiple problems or complications related to one or more underlying causes
 - Identify appropriate generic and cause-specific interventions



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The RAI and Care Planning,

The comprehensive care plan:

- o Is an interdisciplinary communication tool
- Must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being
- Must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.

42 CFR 483.25



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ection V



The RAI and Care Planning₂

Care planning requires one to look at the entire picture of the resident

Human beings are complex, and issues should not be looked at in isolation.

When considering care planning and goals, a resident's preferences for the care they desire to receive should be honored – whether or not you believe that his or her choices are "good" or "bad."

Do we make mistakes in care planning and intervention choices? Can we do everything correctly and still get not so great outcomes?

Is there a way that we can mitigate these types of issues in the care planning process?



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The RAI and Care Planning₃

Ultimately, the creation of a sound care plan requires good assessment and clinical problem solving and decision-making.

A well-developed and executed assessment and care plan:

- Looks at the entire picture of the resident History, physical assessment and observations
- 2. Identifies and incorporates the resident's unique characteristics, abilities, strengths, and needs
- Identifies possible issues/conditions and causes, contributing factors



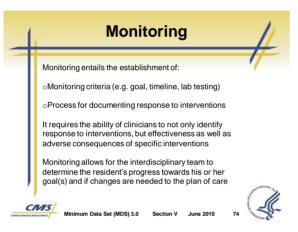
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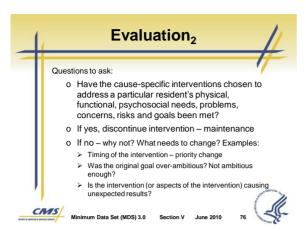
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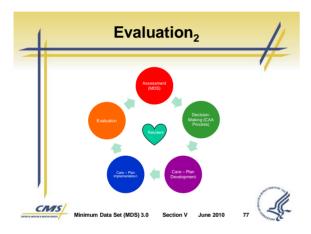


4. Uses data collected to identify resident specific interventions that address a resident's goals – and those goals align with resident preferences for care S.M.A.R.T. Goals 4. Provides a common understanding of the resident to all disciplines 5. Identifies a process for monitoring and evaluating response to care SMART Goals image: http://www.properturent.co.uk/img/goale-object/eve-preferences.pdf Minimum Data Set (MDS) 3.0 Section V June 2010 73









Pinal Thoughts To promote resident's highest practicable level of functioning, improvement where possible and maintenance/prevention of avoidable decline. Remember we are dealing with human beings – not the pressure ulcer in Room 210, or the dressing change in Room 550. Care planning is an essential piece of the care delivery process Minimum Data Set (MDS) 3.0 Section V June 2010 78